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Supreme Court, U.S.
FILED

No. 02 997 DEC 26 2002

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IN THE

Supreme Court of the United States

NANCY MONTALVO, BRIAN VILA AND
EMANUEL L. VILA, ET AL

Petitioners

v.

TERRE BORKOVEC, M.D., ET AL

On Petition For Writ Of Certiorari
To The Supreme Court
of the State of Wisconsin

PETITION FOR WRIT OF CERTIORARI AND APPENDIX

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67 pp

I. WHETHER PARENTS HAVE A FUNDAMENTAL RIGHT TO ELECT COMFORT CARE, RATHER THAN RESUSCITATION OR HEROIC LIFE-SUSTAINING MEASURES FOR EXTREMELY PREMATURE FETAL INFANTS, WHEN THE ACCEPTED MEDICAL LITERATURE ESTABLISHES A SIGNIFICANT PROBABILITY RESUSCITATION WILL LEAD TO SEVERE MORBIDITY.

II. WHETHER THE UNITED STATES CHILD ABUSE AND TREATMENT ACT SHOULD NOT BE CONSTRUED TO PROHIBIT PARENTS FROM ELECTING TO FOREGO HEROIC LIFE-SUSTAINING AND EXPERIMENTAL MEASURES WHEN SUCH MEASURES HAVE A HIGH RISK RATIO OF DOOMING THE CHILD TO LIVE A LIFE FRAUGHT WITH SEVERE NEUROLOGICAL AND PHYSICAL DEFECTS.

PARTIES TO THE PROCEEDING IN THIS COURT

Nancy Montalvo, Brian Vila, and
Emanuel L. Vila, by his Guardian
ad Litem, Timothy J. Aiken,

Petitioners,

v.

Terre Borkovec, M.D.,
Brent W. Arnold, M.D.,
Jonathan H. Berkoff, M.D.,
St. Mary's Hospital of Milwaukee,
Wisconsin Patients Compensation Fund, and
Physicians Insurance Co. of Wisconsin.

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CITATION OF OPINIONS AND ORDERS ENTERED

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Nancy Montalvo, et al., v. Terre Borkovec, M.D., et al, (Wis. Sup. Ct. Table of Dispositions, 2002) (See Appendix A).

Wisconsin Court of Appeals Decision:

Nancy Montalvo, et al., v. Terre Borkovec, M.D., et al, Case No. 01-1933 (May 29, 2002) (See Appendix B).

Trial Court Findings and Orders:

Order For Judgment, Case No. 99-CV-009500 (Milwaukee County Circuit Court, May 2, 2001) (See Appendix C).

STATEMENT OF JURISDICTION

The Wisconsin Supreme Court order denying the Petitioners' petition for review, from which the petitioners now seek review, was entered on September 26, 2002. There have been no rehearings or extensions of time to file this Petition.

The petitioners believe this Court's jurisdiction to review on a writ of certiorari the order in question is conferred by 28 U.S.C. §1257(a).

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED IN THE CASE

Constitutional Provisions:

Fourth Amendment to the United States Constitution

Fifth Amendment to the United States Constitution

Fourteenth Amendment to the United States Constitution

Statutes:

42 U.S.C. §5101 et. seq.

45 C.F.R. §1340 et. seq.

Wisconsin Statute §448.30.

STATEMENT OF THE CASE

On November 21, 1996, petitioners Nancy Montalvo and Brian Vila entered St. Mary's Hospital in Milwaukee, Wisconsin, with Montalvo suffering from pre-term labor symptoms. An ultrasound suggested the baby was 23 and 3/7 weeks old, and weighed about 679 grams.[1] Over the course of the next four hours, attempts to interrupt Montalvo's labor and delay the birth were unsuccessful. Montalvo and Vila were therefore given some time to choose between a natural childbirth and a Caesarian section. In consultation with Vila, Montalvo eventually elected to deliver the baby by Caesarian section. At no time during this four hour period did any doctor or hospital official ever advise Montalvo or Vila of the well-documented risks and complications a baby born at 23 weeks is bound to experience.

Dr. Terre Borkovec performed the cesarean section. At birth, Emanuel was "handed off" to Dr. Arnold, a neonatologist, who successfully performed life-saving resuscitation measures. When Montalvo and Vila eventually saw Emanuel in the Neonatal Intensive Care Unit (NICU), they were astounded. Little Emanuel was hooked up to a mass of tubes, including an umbilical catheter and umbilical arterial catheter, both oral and nasal intubation, placement of a percutaneous central venous line, hyperalimentation, multiple blood transfusions and connected to a high frequency oscillator ventilator. He was subsequently diagnosed with bronchopulmonary dysplasia, bilateral chylothorax, left subclavian thrombus, severe intraventricular hydrocephalus hemorrhage, hyponatremia, hypoalbuminemia, hematological problems, infectious disease problems, ophthalmological deficits, an inguinal hernia and cardiopulmonary and severe developmental delays. Over the course of the next several days, weeks, and months, Emanuel

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[1] The ultrasound overestimated Emanuel's weight which at birth was just 615 grams.

was subjected to numerous treatments, some of which involved significant known risks and others which were actually harmful with no known benefits.[2] Still, neither Montalvo nor Vila were provided any information regarding the long-term prognosis for Emanuel or the risks inherent in the heroic measures and treatments being used to keep him alive.

Indeed, it was not until Vila began researching the prognosis for premature infants, using the medical library at the very hospital where Emanuel was staying, that he realized, and shared with Montalvo, the gravity of the situation they were facing. He was flabbergasted to discover published studies establishing that Emanuel faced a ninety plus percent chance of significant neurological deficit and, at less than 750 grams at birth, would more than likely experience moderate or severe disability, including blindness, deafness, mental retardation, cerebral palsy, a compromised immune system and significant deficiencies in neuropsychological skills. Vila would also eventually learn the American Academy of Pediatrics recommended that:

> Because families bear the emotional and financial consequences of the birth of an extremely low birthweight infant, it is essential to inform prospective parents regarding the expectations for infant outcome and risks and benefits of various approaches to care . . . the range of possible outcomes and management

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[2] The reason for this latter remarkable phenomenon was exposed in 1985 by the National Institute of Child Health and Human Development which took practitioners to task for providing care "based on limited knowledge of new modalities not subjected to critical studies prior to introduction and acceptance" and for changing therapeutic interventions "within months before adequate studies of safety and efficacy are initiated, much less completed." The poorly validated therapies included just about every therapy used on babies in NICUs. *See* National Institute of Child Health and Human Development, *Cooperative Multicenter Network of Neonatal Intensive Care Units (NICUs)*, June 14, 1985.

> options can then be outlined for the patient and her family. . . . counsel about management options may result in the family choosing a noninterventive approach to delivery and management . . . families should be supported in such a decision.

Pediatrics, *Perinatal Care at the Threshold of Viability*, 1995-96, pp. 974-76. Vila also came to understand the counseling they had not been provided could have resulted in a noninterventive approach to delivery and management of the infant.

Vila took the information he found at the hospital to Montalvo and she was similarly stunned to comprehend the reality of Emanuel's situation. After a long period of soul-searching during which they agonized over the implications of what was surely the most important decision they had faced in their lives, they decided they did not wish continuation of the heroic measures which, while they might save Emanuel's life, would likely mean a life fraught with major complications and severe disabilities with a high probability of dooming him to a fate worse than death.

Montalvo and Vila, however, were about to learn that as difficult as it was to reach that decision, infinitely more difficult, and ultimately impossible, would be convincing hospital personnel to honor their decision. Their directive to withdraw the extreme measures sustaining Emanuel's life were flatly rejected. Their requests not to resuscitate Emanuel were likewise ignored.[3] On March 7, 1997, they requested a meeting with the hospital's Bioethics Committee. Not until April 16, 1997, was the meeting held and although they stated their case, only later did they learn the Committee lacked authority to implement their wishes. At no time during Emanuel's six-

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[3] Unfortunately, because they were never given any information about extremely premature babies prior to delivery, they were deprived of an opportunity to decline resuscitation measures at birth.

month hospital stay were they ever offered the option of transferring Emanuel to another hospital that would respect their wishes. Ultimately, the heroic measures to save Emanuel continued unabated and he survived, developing many of the complications, including severe brain bleeds, hydrocephalus, necrotizing enterocolitis, cerebral palsy, bronchopulmonary dysplasia, retinopathy of prematurity, and sepsis; complications Montalvo and Vila reasonably feared he would develop. The hospital's head bioethicist later quipped to Vila that informed consent "is in the eye of the beholder."

On November 19, 1999, Montalvo and Vila filed a suit in Wisconsin state court against St. Mary's Hospital and certain physicians alleging a violation of the informed consent statute, Wis. Stat. §448.30, in performing the cesarean section. More germane to this Petition, the complaint also alleged that Drs. Arnold, Berkoff, and St. Mary's Hospital were negligent for violating the same informed consent statute when they performed "life-saving measures" on Emanuel. The complaint alleged that because the physicians failed to advise the parents of "the risks or potential consequences of a child born at 23 or 24 weeks gestation and/or with a birth weight of less than 750 grams," consent was not informed and a variety of damages resulted.

Berkoff, Arnold, and St. Mary's Hospital moved to dismiss the claims contending the complaint failed to state a claim upon which relief could be granted. During a hearing on the motions, and prior to rendering a decision, the trial court ascertained the plaintiffs were not alleging harm to Emanuel as the result of "extraordinary care measures," but instead, were claiming the decision to use "extraordinary care measures" should have been relegated to them as parents rather than left to the physicians. Lastly, the plaintiffs were not alleging Emanuel was disabled by any actions taken by the physicians or St. Mary's Hospital.

The trial court dismissed the complaint ruling first that the only claim pled for a violation of the informed consent statute in performing the cesarean section was against Arnold. Because, however, he was only a bystander to the delivery, he was not required under the statute to provide informed consent because he did not perform the procedure. Second, the trial court ruled that Wisconsin law does not leave the resuscitation decision upon the birth of a child solely to the parents because of the community's interest in protecting children, and the physicians' commitment to preserving life. On July 18, 2001, Montalvo appealed.

On May 29, 2002, the Wisconsin court of appeals issued a decision affirming the trial court's dismissal of the case. The appellate court excused Dr. Arnold for his failure to advise Vila and Montalvo of the risks associated with the planned treatment of Emanuel, reasoning that the doctrine of informed consent applies only when there is a need to make a choice of available, viable alternatives. (App. B-10). Thereafter, the appellate court held there were two reasons why no available, viable alternatives existed to give rise to the obligation to engage in the informed consent process. (App. B-10-14).

First, the appellate court concluded there was no right not to resuscitate a newly born child or withhold life-sustaining medical care. The appellate court based its decision, in large part, on this Court's holding in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). (App. B, p. 11). Second, the appellate court concluded the existence of the United States Child Abuse Protection and Treatment Act (CAPTA) of 1984, 42 U.S.C. §5101 et. seq., prohibited a failure to act. (*Id.* at 12-13). Indeed, the appellate court reasoned that failure to engage in heroic measures to save Emanuel would have exposed Dr. Arnold to liability under CAPTA, and more specifically, 45 C.F.R. §1340.15(c)(2)(iii).

On June 28, 2002, Vila petitioned the Wisconsin Supreme Court to review the appellate court's decision. On September 26, 2002, the Wisconsin Supreme Court denied that petition. (App. A).

ARGUMENT

I. PARENTS HAVE A FUNDAMENTAL RIGHT TO ELECT COMFORT CARE, RATHER THAN RESUSCITATION OR HEROIC LIFE-SUSTAINING MEASURES FOR EXTREMELY PREMATURE FETAL INFANTS, WHEN THE ACCEPTED MEDICAL LITERATURE ESTABLISHES A SIGNIFICANT PROBABILITY RESUSCITATION WILL LEAD TO SEVERE MORBIDITY.

A. The Treatments Commonly Used In 1996, Coupled With The Studies Available Regarding The Success Of Those Treatments, Established A Statistical Probability In Excess Of Ninety Percent That Emanuel Would Suffer A Significant Neurological Deficit.

The most pressing issues of our time, it has been said, are not matters of engineering, but of human values. Nowhere is the need for urgent review of these values greater than in the field of treatment of extremely premature fetal infants.[4] The practical implications of the evolution of treatment in the NICU has been described:

> Regionalization of perinatal care and technological advances in the 1970s were accompanied by the improved survival of preterm infants born after 26 weeks' gestation with birth weights above 750 g. Beginning in the early 1980s, active obstetrical and

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[4] Use of the term "fetal infants" should not conjure up this Court's jurisprudence on abortion. This is not a case about abortion, but rather, informed consent. Instead, the term "fetal infants" is used because it more accurately depicts these second trimester infants who remain truly fetal throughout their transfer from a natural womb to the artificial womb known as the NICU. This terminology is also consistent with St. Mary's medical records which described Emanuel as a "singleton male fetus" following his birth.

> delivery-room care was applied to progressively smaller and less mature infants. Survival increased, but the rates of neonatal morbidity (from chronic lung disease, septicemia, periventricular hemorrhage, and retinopathy of prematurity), length of hospitalization, and costs of care were exceptionally high as compared with those for larger, more mature infants.

Hack, *Outcomes of Extremely Immature Infants - A Perinatal Dilemma*, New England Journal of Medicine, Vol. 329, No. 22, p. 1649 (1993).

Although the morbidity rate for fetal infants such as Emanuel has not materially changed in the six years since his birth, this case must be examined from the perspective of what was commonly known about such infants at the time Montalvo and Vila entered the hospital on November 21, 1996.[5] Indeed, since the thrust of their claim is that they were entitled to receive information regarding Emanuel's situation and to make medical decisions for him based on that information, it is helpful to review a compendium of surveys revealing how 1,131 neonatologists nationwide were handling these situations midway through the past decade.

The study, reported in a 1995 issue of the Journal of Perinatology, indicated that ninety percent of neonatologists counseled parents that between 75 percent and 100 percent of fetal infants born at 23 weeks gestation die. Sanders, et al, *Perceptions of the Limit of Viability: Neonatologists' Attitudes Toward Extremely Preterm Infants*. Journal of Perinatology, Vol. 15, No. 6, p. 496 (1995). Nearly 30 percent of neonatologists

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[5] While medical advances have improved the *survival* rate for infants such as Emanuel, novel and sometimes harmful (e.g., steroids) treatments in the NICU have actually worsened the *morbidity* rate, which signifies an increasing number of these cases in the coming years.

were unwilling to resuscitate such infants. *Id.* at 497. More importantly, when a fetal infant successfully resuscitated in the delivery room began to decompensate in spite of maximal medical treatment, a majority of neonatologists were unwilling to provide full resuscitation for fetal infants born at less than 27 weeks. *Id.* at 498. Indeed, more than half the neonatologists were willing to actively encourage parents to withdraw support when such an infant born at 23 weeks gestation continued to decompensate. *Id.*

Most interesting to this case is that most neonatologists would consult with parents regarding setting limits or withdrawal of support for infants 23 to 27 weeks gestation. *Id.* As one neonatologist noted:

> In general, for the very, very tiny baby, I am as explicit as possible with parents prior to delivery. The usual agreed-upon course is aggressive DR [sic] and early intervention with withdrawal of support later in the event of relentless respiratory decompensation and/or catastrophic intracranial hemorrhage. In my experience, very few parents opt for the extremes of care for their 23-25 week preemie.

Id. at 498. Another noted that "[d]iscussion with family regarding risks of premature delivery and borderline viability (~23 wks) is *the* most important measure to plan resuscitation." *Id.* at 498. (Emphasis in original).

The common denominator among virtually all neonatologists, making its absence in this case particularly conspicuous, was the consultation with the parents and their involvement in the decision-making process. As another neonatologist observed:

> I feel that *informed* parental decisions regarding initiation and/or withdrawal of care are paramount

> in infants < 26 weeks. This is high risk experimental medicine. No one should decide but the family.

Id. at 499. (Emphasis in original). Presaging the need for this Court's guidance on the issue raised herein, Sanders concluded by noting that physicians lacked "an approach to medical decision making for infants born at the limit of viability that maximizes the possibility of a good outcome while minimizing suffering."[6] *Id.* at 500.

There were good reasons why neonatologists approached the question of resuscitation with such extraordinary caution: It was well documented that most fetal infants kept alive until weaned off of life-sustaining interventions went on to a lifetime of suffering from a variety of afflictions. For example, one study reported that at 23 weeks gestational age, 93 percent of infants either died or had major morbidities at the time of discharge. Allen, *The Limit of Viability - Neonatal Outcome of Infants Born at 22 to 25 Weeks Gestation,* New England Journal of Medicine, Vol. 329, No. 2, pp. 1597-1601 (1993). Allen forecasted severe handicap for 50 percent of infants born at 23 weeks. *Id.* A separate study by the University of Connecticut School of Medicine reported the figure at 95 percent. Hussain, et al, *Pre-discharge Outcomes of 22-27 Weeks Gestational Age Infants Born At Tertiary Care Centers In Connecticut: Implications for Perinatal Management,* Connecticut Medicine Vol. 62, No. 3, p. 134 (1998). Hussain recommended that:

> For infants born at 23 and 24 weeks gestational age, given the very high mortality rates, the very poor chances for survival without a major morbidity, and

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[6] Two thirds of neonatologists stated that parental wishes regarding resuscitation influenced their decision whether to resuscitate fetal infants born at 23 to 24 weeks gestational age. *Id.* at 500. At a minimum, neonatologists should frequently reassess survival and short-term morbidity data from their own institution and incorporate this information into counseling of parents. *Id.* at 501.

> the long length of suffering in the neonatal intensive care unit (average length of stay > 100 day), treatment may be considered optional, with parents reserving the right to decline life support for their infant. . . . Detailed discussions held with parents should be done before undertaking resuscitative efforts under these circumstances.

Hussain, supra, at 136.

Other studies confirmed the ominous prospects for these infants. A study in Ontario reported the presence of handicap in 50 percent of survivors at 23 weeks. Whyte, *Extreme Immaturity: Outcome of 568 Pregnancies of 23 - 26 Weeks Gestation,* 1993 Obstet Gynecol 82, pp. 1-7. A regional study in Oxford, England, reported moderate-to-severe functional handicap at age four in 80 percent of surviving infants born at less than 25 weeks. Johnson, *Functional Abilities at Age 4 Years of Children Born Before 29 Weeks of Gestation,* 306 B.M.J. pp. 1715-18 (1993). In 1993, the Fetus and Newborn Committee of the Canadian Paediatric Society recommended flexibility with regard to resuscitation for infants born at 23 or 24 weeks, with careful consideration of the views of the family. *Approach to the Woman with Threatened Birth of an Extremely Low Gestational Age Infant (22 - 26 Completed Weeks),* Canadian Paediatric Society Secretariat. (Oct. 1993).

B. The Constitution Confers Fundamental Liberty And Privacy Interests To Refuse Unwanted Medical Treatment.

Although the entity which in this case supplanted the petitioner's wishes with its own was ostensibly the hospital and its physicians, it was the State of Wisconsin which ultimately placed its imprimatur on that infringement. Indeed, the appellate court concluded that because of state and federal laws, and the decisions of this Court, the hospital was required

to act as it did. In this context the petitioners' fundamental rights must be examined.

Notions of liberty are inextricably entwined with the idea of physical freedom and self-determination. *Cruzan* at 287 (O'Connor, J., concurring). For example, this Court has construed the Due Process Clause to preclude physically invasive recoveries of evidence not only because such procedures are "brutal" but also because they are "offensive to human dignity." *Rochin v. California*, 342 U.S. 165, 174 (1952). It has interpreted the Constitution to interpose barriers to a State's efforts to sterilize some criminals not only because the proposed punishment would do "irreparable injury" to bodily integrity, but because "[m]arriage and procreation" concern "the basic civil rights of man." *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942). The sanctity, and individual privacy, of the human body is obviously fundamental to liberty. Every violation of a person's bodily integrity (and human dignity) is an invasion of his or her liberty. *Washington v. Harper*, 494 U.S. 210, 237, (1990) (Stevens, J., concurring in part and dissenting in part).

It was with these principles in mind that this Court held the Due Process Clause of the Fourteenth Amendment confers a significant liberty interest in avoiding unwanted medical treatment. *Washington, supra*. Whatever other liberties protected by the Due Process Clause are fundamental, "those liberties that are 'deeply rooted in this Nation's history and tradition'" are among them. *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986) (*quoting Moore* v. *East Cleveland*, 431 U.S. 494, 503 (1977) (plurality opinion)). "Such a tradition commands respect in part because the Constitution carries the gloss of history." *Richmond Newspapers, Inc. v. Virginia*, 448 U.S. 555, 589 (1980) (Brennan, J., concurring in judgment).

The right to be free from medical attention without consent, and to determine what shall be done with one's own

body, is deeply rooted in this Nation's traditions. *Cruzan* at 270. This right has long been "firmly entrenched in American tort law" and is securely grounded in the earliest common law. *Cruzan* at 269. "[E]ach man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery or other medical treatment." *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960). The inviolability of the person is as "sacred" and "carefully guarded" as any common law right. *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251-252 (1891). Thus, freedom from unwanted medical attention is unquestionably among those principles "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934).

Nor does incompetency deprive an individual of his fundamental rights. *See Youngberg v. Romeo*, 457 U.S. 307, 315, 316, 319 (1982) (severely retarded man's liberty interests in safety, freedom from bodily restraint, survive involuntary commitment); *Jackson v. Indiana*, 406 U.S. 715, 730, 738 (1972) (Indiana could not violate due process and equal protection rights of a mentally retarded deaf mute by committing him for indefinite amount of time simply because he was incompetent to stand trial on criminal charges filed against him). The question is not whether an incompetent has constitutional rights, but how such rights will be exercised. *Cruzan* at 280. As this Court explained:

> The law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally. Children, the insane, and *those who are irreversibly ill with loss of brain function, for instance, all retain 'rights,'* to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind.

Thompson v. Oklahoma, 487 U.S. 815, 825, n. 23 (1988) (Emphasis added). As another court observed, "[t]o deny [its] exercise because the patient is unconscious or incompetent would be to deny the right." *Foody v. Manchester Memorial Hospital*, 482 A.2d 713, 718 (Conn. Sup. 1984). Moreover, there is nothing novel about permitting a next friend to assert constitutional rights on behalf of an incompetent patient who is unable to do so. *See, e.g., Youngberg*, 457 U.S. at 310; *Whitmore v. Arkansas*, 495 U.S. 149, 161-164 (1990).

Dying is a part of "the life which characteristically has its place in the home," *Poe v. Ullman*, 367 U.S. 497, 551 (1961) (Harlan, J., dissenting). The "integrity of that life is something so fundamental that it has been found to draw to its protection the principles of more than one explicitly granted Constitutional right," *id.*, at 551-552, and this Court's decisions have demarcated a "private realm of family life which the state cannot enter." *Prince v. Massachusetts*, 321 U.S. 158, 166-167 (1944). The liberty to make the choices constitutive of private life is so fundamental to our "concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), that those choices must occasionally be afforded more direct protection. *See, e.g., Meyer v. Nebraska*, 262 U.S. 390 (1923); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Roe v. Wade*, 410 U.S. 113 (1973); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 772-782 (1986) (Stevens, J., concurring). At its most profound level, this case touches the core of human dignity and addresses the very process of how life is created by raising the question of whether a woman has a fundamental privacy right to miscarry her child or whether third parties will instead be allowed to socially engineer human reproduction to promote a particular philosophy. The constitutional decisions identifying rights pertaining to bodily integrity, like the common law tradition upon which they built, are mindful that the "makers of our Constitution . . . recognized the significance of man's spiritual nature." *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

It is against this background of decisional law, and the constitutional tradition it illuminates, that the right to be free from unwanted life-sustaining or other medical treatment must be understood. That right does not presuppose abandonment of the desire for life. Nor is it reducible to a mere guarantee against the infliction of bodily discomfort. Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental," *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934), and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator. *See Meachum v. Fano*, 427 U.S. 215, 230 (1976) (Stevens, J., dissenting).

C. The United States Constitution Recognizes The Fundamental Right Of Parents To Make The Most Important Of Decisions In Their Children's Lives.

The parent-child relationship has long been acknowledged to have a constitutional dimension. Although not explicitly mentioned in the United States Constitution, a parent's right to participate in the rearing of children is a recognized fundamental right which is constitutionally protected. *Wisconsin v. Yoder*, 406 U.S. 205, 213-214 (1972); *Zablocki v. Redhail*, 434 U.S. 374, 384-385 (1978). The Supreme Court long ago emphatically declared that a parent's right to "the companionship, care, custody and management of his or her children" is an interest "far more precious" than any property right, *May v. Anderson*, 343 U.S. 528, 533 (1953), and "an important interest that understandably warrants deference and, absent a powerful countervailing interest, protection." *Lassiter v. Department of Social Services*, 452 U.S. 18, 27 (1981).

The constitutionally protected liberty in family relationships and child rearing is not a recent innovation:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

Yoder, 406 U.S. 205 at 232. As this Court so bluntly noted, a child is not a mere creature of the state. *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925).

Nearly fifty years later, this Court reaffirmed that principle when it stated:

> It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder. It is in recognition of this that these decisions have respected the private realm of family life which the State cannot enter.

Prince, 321 at 166. *See also Quilloin v. Walcott*, 434 U.S. 246 (1978). A child's corresponding right to protection from interference in the relationship derives from the psychic importance of having life's decisions made by a loving, responsible, reliable adult. *Franz v. United States*, 707 F.2d 582, 595-599 (U.S. Ct. App. D.C. Circuit 1983).

The law's concept of the family rests on the presumption that parents possess what a child lacks in maturity, experience and capacity for judgment required in making life's difficult decisions. *Parham v. J.R.*, 442 U.S. 584, 602 (1979). More importantly, it has historically been recognized that natural bonds of affection lead parents to act in the best interests of their children. *Id.* The statist notion that governmental power should supersede parental authority in *all* cases because *some*

parents abuse and neglect children has been called repugnant to the American tradition. *Id.* As this Court has stated:

> Simply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state. . . . Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. **Parents can and must make those judgments.**

Parham, 442 U.S. at 603. (Emphasis added).

D. This Court's Decision In *Cruzan v. Director, MDH*, 497 U.S. 261 (1990), Does Not Abrogate This Fundamental Right Of Parents Because Said Right Was Not Addressed In That Case.

In ruling Emanuel's parents did not state a cognizable claim, the Wisconsin court of appeals relied heavily on this Court's decision in *Cruzan, supra*. In *Cruzan*, this Court addressed the constitutionality of Missouri's requirement that there exist clear and convincing evidence of an adult patient's desire to have life-sustaining treatment withdrawn before a surrogate can compel the withdrawal of such treatment. Nancy Cruzan, who was in a persistent vegetative state resulting from an automobile accident, had told her roommate she would never wish to have her life sustained unless it was halfway normal. In their effort to disconnect the artificial nutrition and hydration tubes maintaining her life, Cruzan's parents relied on these statements as proof of her intentions. The Supreme Court of Missouri ultimately ruled the statements unreliable for purposes of determining her intent, and therefore insufficient to support her parents' claim to exercise substituted judgment on Cruzan's behalf. This Court held that insofar as a competent

person's constitutionally protected liberty interests to refuse medical treatment must be balanced against a state's interests, Missouri did not commit constitutional error in concluding clear and convincing evidence was required, and moreover not present, in the case before it. *Id.* at 284-85.

While the issue this Court addressed in *Cruzan* may appear, at first blush, to be on all fours with the facts of this case, there is a critical distinction which transforms the resultant analysis. The Wisconsin court of appeals did not pause to consider that at the time she became incapacitated, Nancy Cruzan was an adult, and no longer under the legal authority of her parents. Therefore, she was fully capable, in her lifetime, of expressing her own wishes with regard to life-sustaining treatment. She could have executed a living will or otherwise communicated her intentions (just as she did, though not to the courts' satisfaction, to her roommate). Accordingly, the proper focus in *Cruzan* was what Nancy wanted and her parents, their fundamental right extinguished by her coming of age, could not legally substitute their judgment for hers.

Standing in stark contrast are the facts of this case where Emanuel was a fetal infant who was never capable of forming, much less expressing, an intent or preference in this regard. Consequently, the focus of this case could not have been what he wanted, but instead, was necessarily shifted to what his parents, exercising their fundamental duty and obligation to make decisions on his behalf, wanted and believed was best for him. Ultimately, however, the appellate court, erroneously relying on the analysis of *Cruzan*, and failing to appreciate there could be no determination of what Emanuel would have wanted except as expressed by his parents, held it proper to supplant what Emanuel's parents wanted with what the state putatively ordained. In short, the appellate court concluded the government's wishes, as expressed in *Cruzan* and CAPTA, trumped Montalvo's and Vila's wishes.

The appellate court also reasoned that because an emergency arose at Emanuel's birth, physicians were not required to cease emergency actions and explain possible options to Montalvo and Vila. This reasoning, however, was predicated upon the faulty premise that the need to institute extraordinary measures to resuscitate Emanuel upon his birth was unforeseeable and arose unexpectedly. It would be nothing short of a medical miracle if a fetal infant born as prematurely as Emanuel were to survive without medical intervention. The doctors clearly knew Emanuel would need major medical intervention and would be destined for a several-month stay in the NICU and had four hours to advise the petitioners of this fact and obtain their informed consent to treatment. If there was an emergency vis-a-vis the informed consent requirement, it was of the physician's own making, and they should not have been permitted to hide behind this legal fiction.

E. The Appellate Court's Ruling That The Petitioners Had No Protected Right To Withhold Life-Sustaining Care From Emanuel Violated Their Fundamental Right As Parents To Make That Decision.

If a requirement imposed by a State "significantly interferes with the exercise of a fundamental right, it cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests." *Zablocki*, 434 U.S. at 388. The Constitution imposes on this Court the obligation to "examine carefully . . . the extent to which [the legitimate government interests advanced] are served by the challenged regulation." *Moore*, 431 U.S. at 499. *See also Carey v. Population Services International*, 431 U.S. 678, 690 (1977) (invalidating requirement that bore "no relation to the State's interest"). Fundamental rights are protected not only against heavy-handed frontal attack, but also from being stifled by more subtle governmental interference. *Bates v. Little Rock*, 361 U.S. 516, 523 (1960).

Although the right to be free of unwanted medical intervention, and the right to make medical decisions on behalf of one's child, like other constitutionally protected interests, is not absolute, no State interest could outweigh the rights of individuals in the petitioners' position in this case. Whatever a State's possible interests in mandating life-support treatment under other circumstances, there was no legitimate principle of justice being upheld by insisting Emanuel remain on life-support systems if it was his parents' wishes, and indeed his wish as expressed by his parents, not to do so. Society as a whole was not benefitted by Emanuel's receiving medical treatment. No third party's situation was improved (except for the hospital and physicians who collectively billed nearly $1 million for their services), and no harm to others was averted. The only state interest asserted here was a general interest in the preservation of life. But the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the choice to avoid medical treatment.

The regulation of constitutionally protected decisions must be based on legitimate state concerns *other than* disagreement with the choice the individual has made. Otherwise, the interest in liberty protected by the Due Process Clause would be a nullity. *Hodgson v. Minnesota*, 497 U.S. 417, 435 (1990) (Opinion of Stevens, J.) (emphasis added). Thus, the State's general interest in life must accede to the petitioners' particularized and intense interest in self-determination in their choice of medical treatment or non-treatment. There was simply nothing legitimately within the State's purview to be gained by superseding their decision.

Where it is not possible to determine what choice an incompetent patient would make, a State's role as *parens patriae* should not permit the State automatically to make that choice itself. *See, e.g., Cruzan* at 286 (explaining the Due Process Clause does not require a State to confide the decision

to "anyone but the patient herself"). It does not follow that it is constitutionally acceptable for the State to invariably assume the role of deciding for the patient, or the patient's parents, when the Constitution confers upon them the fundamental right and duty to make such a decision. A State's legitimate interest in safeguarding a patient's choice cannot be furthered by simply appropriating it.

In *Cruzan*, this Court was concerned that while close family members may have a strong feeling about the question, "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." *Id.* at 286. Aside from the fact that such an analysis reduces the question in this case to an impossible hypothetical, it also leads to another question: Is there any reason to suppose that a State is *more* likely to make the choice that the patient would have made than someone who knew the patient intimately? As Justice Brennan observed in his dissent in *Cruzan*, to ask this question is to answer it. *Id.* at 327. As the New Jersey Supreme Court observed: "Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. . . . It is . . . they who treat the patient as a person, rather than a symbol of a cause." *In re Jobes,* 529 A.2d 434, 445 (N.J. Sup. Ct. 1987).

The State, by contrast, is a stranger to the patient. A State's inability to discern an incompetent patient's choice still need not mean a State is rendered powerless to protect that choice. But the Due Process Clause should prohibit a State from doing more than that. A State should ensure the person who makes the decision on the patient's behalf is the one whom the patient himself would have selected to make that choice for him. A State should also exclude from consideration anyone having improper motives. But a State generally must either

repose the choice with the person whom the patient himself would most likely have chosen as proxy or leave the decision to the patient's family. In this case, those alternatives were one and the same.

II. THE UNITED STATES CHILD ABUSE PROTECTION AND TREATMENT ACT SHOULD NOT BE CONSTRUED TO PROHIBIT PARENTS FROM ELECTING TO FOREGO HEROIC LIFE-SUSTAINING AND EXPERIMENTAL MEASURES WHEN SUCH MEASURES HAVE A HIGH RISK RATIO OF DOOMING THE CHILD TO A LIFE FRAUGHT WITH SEVERE NEUROLOGICAL AND PHYSICAL DEFECTS.

The appellate court also relied on the United States Child Abuse Protection And Treatment Act, known as "CAPTA." *See* 42 U.S.C. §5101 et. seq. (App. B-12). Properly concluding Wisconsin is subject to CAPTA's regulations, the appellate court focused on 45 C.F.R. §1340.15(b)(1) which prevents "the withholding of medically indicated treatment from a disabled infant with a life-threatening condition." Thereafter, the appellate court turned to 45 C.F.R. §1340.15(b)(2) which defines "withholding of medically indicated treatment" as:

> [T]he failure to respond to the infant's life-threatening conditions by providing treatment . . . which, in the treating physician's . . . reasonable medical judgment, will be most likely to be effective in . . . correcting all such conditions. . . .

(App. B-13). The appellate court then reasoned "[t]he implied choice of withholding treatment, proposed by the [parents], is exactly what CAPTA prohibits." (*Id.*).

The language of 45 C.F.R. 1340.15(b) defines "medical neglect" as the failure to provide adequate medical care "in the context of the definitions of 'child abuse and neglect.'" The

appellate court's reading of CAPTA fails to give expression to actual congressional intent. The notes to 42 U.S.C. §5101 (which establishes the Office on Child Abuse and Neglect) reveal the Congressional findings giving rise to CAPTA were concerned with child victims of abuse and neglect who fail to receive adequate protection or treatment. The legislation says nothing about extremely premature infants and there is nothing in the record to suggest Emanuel was a victim of abuse or neglect. Furthermore, the appellate court's attempt to force the square peg of this case into the round hole of CAPTA fails because, for reasons already noted, it cannot be said the multitude of treatments to which Emanuel was subjected were "likely to be effective . . . in correcting all such conditions."

Ironically, if the appellate court's overly broad reading of CAPTA were carried to its logical conclusion, it would actually prohibit many of the life-sustaining measures the appellate court reasoned it required, because many of those treatments were harmful. For example, the New England Journal of Medicine reported, nearly eight years before Emanuel's birth, that high-frequency oscillatory ventilation offered no advantage over conventional mechanical ventilation in the treatment of respiratory failure in preterm infants, but on the contrary, was associated with undesirable side effects. HIFI Study Group, *High-Frequency Oscillatory Ventilation Compared with Conventional Mechanical Ventilation*, New England Journal of Medicine, Vol. 320, No. 2, pp. 88-93 (Jan. 12, 1989). The study concluded high frequency oscillatory ventilation did not decrease the forty percent incidence of bronchopulmonary dysplasia, but significantly increased the incidence of intercranial hemorrhage (which Emanuel developed)[7] and isolated periventricular leukomalacia. *Id.* at p. 91, If, as the appellate

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[7] Indeed, the appellate court neglects to mention that 45 C.F.R. 1340.15(b)(2) expressly exempts the failure to provide treatment to an infant when such treatment would not reasonably "be effective in ameliorating . . . all of the infant's life-threatening conditions . . . [or] would be inhumane."

court concluded, CAPTA required physicians to subject Emanuel to a treatment which offered no benefit, but instead, posed a significant risk of serious harm, then CAPTA would promote the precise problem it purports to prohibit.[8]

Moreover, some circuits have held that child beneficiaries of CAPTA have no private right to enforce it. *See Doe v. District of Columbia*, 93 F. 3d 861, 865 (D.C. Cir. 1996); *Tony L. By and Through Simpson v. Childers*, 71 F. 3d 1182 (6th Cir. 1995) cert. den., 116 S. Ct. 1834 (1996). If so, this undermines the appellate court's public policy rationale that the specter of lawsuits under CAPTA presented Emanuel's physicians with a "lose-lose enigma." (App. B-18). At best, CAPTA might provide a physician an affirmative defense, with a factual question for the jury as to whether his medical judgment was reasonable, but it should not be used to wholly abrogate a parent's fundamental rights. Ultimately, this is the crux of the issue. If CAPTA is read to preclude parents from fundamentally deciding to decline treatment for their critically ill children, then for the reasons set forth in Section I of this petition, CAPTA would be unconstitutional.

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[8] There are other examples. Emanuel was given a commercial intravenous-feeding solution which, six months before his birth, was believed to cause aluminum neurotoxicity resulting in a one point loss in the Mental Development Index for each day of intravenous feeding. Bishop, *Aluminum Neurotoxicity in Preterm Infants Receiving Intravenous-Feeding Solutions*, New England Journal of Medicine, Vol. 336, No. 22 (May 29, 1997). More than six years before Emanuel's birth, the use of dexamethasone (a steroid) intravenous catheters did not result in any long-term improvements for fetal infants, but caused subtle adverse effects on brain and lung growth and was suspected of being causally related to bronchopulmonary dysplasia. Kazzi, *Dexamethasone Effects on the Hospital Course of Infants with Bronchopulmonary Dysplasia who are Dependent on Artificial Ventilation*, Pediatrics, Vol. 86, No. 5 (Nov. 1990).

CONCLUSION

The issues raised by this Petition concern what one commentator referred to as the wide gulf separating those who believe all decisions about intensive neonatal treatment must be taken in the child's best interests (with parents and society secondary), as opposed to others who believe that in ambiguous situations, the wishes and interests of the parents must be given first consideration. Swan J.M. Concluding remarks. In: Kuhse H., de Garis C, eds. *The Tiniest Newborns: Survival - What Price?* Melbourne, Australia: Monash Centre for Bioethics; 1984. Another well-respected writer on the subject notes:

> The dramatic increase of technical power in neonatal medicine has made possible an unprecedented form of extremism. This change . . . is nothing less than a radical social revolution. When the fulfillment of an eager team's dream of rescue brings about the real life enactment of a family's worst nightmare, something momentous has happened to the unwritten rules of common decency.

Silverman, *Overtreatment of Neonates? A Personal Retrospective*, Pediatrics Vol. 90, No. 6, p. 971 (Dec. 1992).

The competing values framed by this Petition, however, stand for an even greater principle, for:

> Of all tyrannies, a tyranny exercised for the good of its victims, may be the most oppressive. Those who torment us for our own good, will torment us without end, for they do so with the approval of their own conscience.

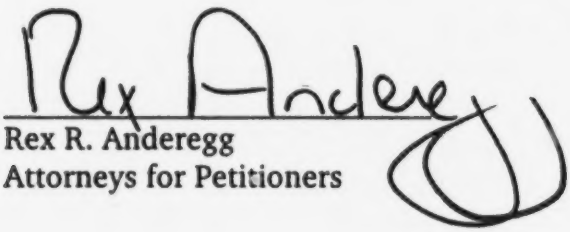
Lewis J., *The Humanitarian Theory of Punishment*, Res Judicata, 1952; 6:244-228. The state-sanctioned justification for

depriving the petitioners of information and supplanting their wishes with its own - that it was for their and Emanuel's own good - is repugnant to their fundamental rights of liberty, privacy and, as parents, to make decisions regarding their children.

For all of the foregoing reasons, the petitioners respectfully request that the United States Supreme Court grant their Petition.

Dated this 23rd day of December, 2002.

ANDEREGG & MUTSCHLER, LLP



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Attorneys for Petitioners

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(Additional Parties on Page Two - Not Available)

You are hereby notified that the Court has entered the following order:

No. 01-1933 Nancy Montalvo v. Terre Borkovec, M.D.
L.C. #99CV9500

A petition for review pursuant to Wis. Stat. § 808.10 having been filed on behalf of plaintiffs-appellants-petitioners, Nancy Montalvo, et al., and considered by this court;

IT IS ORDERED that the petition is denied, with $50 costs to be divided between the respondents.

Bablitch, J., did not participate.

Cornelia G. Clark
Clerk of Supreme Court

COURT OF APPEALS
DECISION
DATED AND FILED
May 29, 2002

Cornelia G. Clark
Clerk of Court of Appeals

NOTICE

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. *See* § 808.10 and RULE 809.62, STATS.

Appeal No. 01-1933

Cir. Ct. No. 99 CV 9500

STATE OF WISCONSIN

IN COURT OF APPEALS
DISTRICT I

NANCY MONTALVO, BRIAN VILA AND EMANUEL L. VILA, BY HIS GUARDIAN AD LITEM, TIMOTHY J. AIKEN,

PLAINTIFFS-APPELLANTS,

BLUE CROSS BLUE SHIELD UNITED OF WISCONSIN, WISCONSIN DIVISION OF HEALTH CARE FINANCE, AND PRIMECARE HEALTH PLAN, INC.,

INVOLUNTARY PLAINTIFFS,

V.

TERRE BORKOVEC, M.D.,

DEFENDANT,

BRENT W. ARNOLD, M.D., JONATHAN H. BERKOFF, M.D., ST. MARY'S HOSPITAL OF MILWAUKEE, WISCONSIN PATIENTS COMPENSATION FUND, AND PHYSICIANS INSURANCE CO. OF WISCONSIN,

DEFENDANTS-RESPONDENTS.

APPEAL from judgments of the circuit court for Milwaukee County: MEL FLANAGAN, Judge. *Affirmed.*

Before Wedemeyer, P.J., Fine and Schudson, JJ.

¶1. WEDEMEYER, P.J. Nancy Montalvo, Brian Vila and Emanuel L. Vila (by his guardian ad litem, Timothy J. Aiken) appeal from judgments entered after the trial court dismissed their complaint against Dr. Brent W. Arnold, Dr. Jonathan H. Berkoff, St. Mary's Hospital of Milwaukee, the Wisconsin Patients Compensation Fund and Physicians Insurance Co. of Wisconsin. The complaint alleged that the defendants were negligent for failing to sufficiently inform Montalvo and Vila of the risk of disability to Emanuel following his premature birth by cesarean section.

¶2. Montalvo, Vila, and Emanuel raise ten arguments.[1] We address only those arguments necessary to the resolution of this case. Because under our current rules of pleading and procedure, substantive law, and public policy the plaintiffs' claims cannot be pursued, we affirm.

I. BACKGROUND

¶3. On November 21, 1996, Montalvo entered St. Mary's Hospital in Milwaukee, Wisconsin, with pre-term labor symptoms. An ultrasound revealed that the baby was 23 and 3/7 weeks old, and weighed 679 grams. Attempts to interrupt her labor and delay the birth were unsuccessful. Prior to

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[1] They argue: (1) Montalvo had a right to informed consent prior to the cesarean procedure; (2) the decision to use potentially harmful therapy is subject to informed consent; (3) Wisconsin abortion law does not apply to this situation; (4) with the exception of the drug/alcohol abuse provisions of ch. 48, expectant mothers have the absolute right to control the manner of delivery; (5) the concept of "viability" cannot mean preservation of life at any cost; (6) the lifelong ramifications of perinatal treatment decisions mandate that such decisions be made by the parents only after being fully informed of all the risks and alternatives; (7) federal funding statutes do not control Wisconsin informed consent law; (8) the Americans with Disabilities Act does not control this case; (9) there is no constitutional basis for federal or state government interference in the medical decision-making process; and (10) compelling parents to agree to surgeries or therapies whose benefit versus risk analysis is unclear puts an unfair burden on parents.

delivery of the child, the parents executed an informed consent agreement for a cesarean procedure.

¶4. Dr. Terre Borkovec performed the cesarean section. At birth, Emanuel was "handed off" to Dr. Arnold, a neonatologist, who successfully performed life-saving resuscitation measures.

¶5. On November 19, 1999, Montalvo filed a complaint against Borkovec and Arnold alleging that both physicians violated the informed consent statute, Wis. Stat. § 448.30, in performing the cesarean section. The complaint also alleged that Arnold, Berkoff, and St. Mary's Hospital were negligent for violating the same informed consent statute when they performed "life-saving measures" for Emanuel. The complaint alleged that because the physicians failed to advise the parents of "the risks or potential consequences of a child born at 23 or 24 weeks gestation and/or with a birth weight of less than 750 grams," consent was not informed and a variety of damages resulted.

¶6. Berkoff, Arnold, and St. Mary's Hospital moved to dismiss the claims contending that the complaint failed to state a claim upon which relief could be granted pursuant to Wis. Stat. § 802.06(2)(a)6. During a hearing on the motions, and prior to rendering a decision, the trial court ascertained that

the plaintiffs were not alleging harm to Emanuel as the result of "extraordinary care measures" but were claiming that the decision to use "extraordinary care measures" should have been relegated to them as parents rather than left to the physicians. Lastly, the plaintiffs were not alleging that Emanuel was disabled by any actions taken by the physicians or St. Mary's Hospital.

¶7. The trial court dismissed the complaint ruling first that the only claim pled for a violation of the informed consent statute in performing the cesarean section was against Arnold.[2] Because, however, he was only a bystander to the delivery, he was not required under the statute to provide informed consent because he did not perform the procedure. Second, the trial court ruled that Wisconsin law does not leave the resuscitation decision upon the birth of a child solely to the parents because of the community's interest in protecting children, and the physicians' commitment to preserving life. Montalvo now appeals.

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[2] For reasons undisclosed in the record, Dr. Terre Borkovec was voluntarily dismissed from the action.

II. ANALYSIS

Standard of Review

¶8. A motion to dismiss a complaint for failure to state a claim upon which relief may be granted tests the legal sufficiency of the pleading. *Evans v. Cameron*, 121 Wis. 2d 421, 426, 360 N.W.2d 25 (1985). As a question of law, we review the trial court's decision independently, keeping in mind the value we accord the trial court's analysis. We must affirm a judgment dismissing a complaint for failure to state a claim if, upon review of the complaint, as liberally construed, it is quite clear that under no conditions can the plaintiff recover based upon the facts alleged and inferences reasonably drawn. *Bartley v. Thompson*, 198 Wis. 2d 323, 332, 542 N.W.2d 227 (Ct. App. 1995). With these rubrics of review in mind, we now examine the issues dispositive of this appeal.

A. Rules of Pleading and Procedure.

¶9. The original defendants in this case were Drs. Borkovec, Arnold, Berkoff and St. Mary's Hospital. Borkovec, who performed the cesarean section, was voluntarily dismissed from the case. That left Arnold as the only target allegedly negligent for failure to obtain a properly informed consent for the performance of the cesarean section. Yet, it was undisputed that Arnold, although present when the cesarean section

occurred, did not participate in the procedure. The trial court construed Wis. Stat. § 448.30 to provide that only the treating physician, here Borkovec, owed the responsibility of informed consent to the parents. Borkovec, however, was no longer a party to the action. The statute does not impose the duty of informed consent on non-treating physicians. Because Arnold neither participated nor assisted, he was not a treating physician with respect to the cesarean procedure, and did not have a duty to comply with the informed consent statute.

¶10. Thus, the trial court concluded that with respect to the cesarean procedure, no claim had been properly pleaded upon which relief could be granted. We know of no authority to the contrary. In this respect, the trial court did not err. On appeal, Montalvo has not contested this ruling. Consequently, the only claims remaining to be addressed by the trial court were the failure to properly obtain informed consent relating to resuscitation efforts by Arnold, Berkoff, and St. Mary's Hospital.

B. Substantive Law and Statutory Law.

¶11. On the remaining informed consent issue relating to the resuscitation efforts, the essential question is whether the complaint states a legally cognizable claim against the remaining defendants. The trial court ruled it did not.

¶12. Our informed consent law requires a physician to disclose information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis. *Kuklinski v. Rodriguez*, 203 Wis. 2d 324, 329, 552 N.W.2d 869 (Ct. App. 1996). It is a right found in both the common law of this state and in statutory provisions. Wisconsin Stat. § 448.30 codified the duty-to-disclose law recognized by *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 13, 227 N.W.2d 647 (1975), and reads:

> **Information on alternate modes of treatment.** Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:
>
> (1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
>
> (2) Detailed technical information that in all probability a patient would not understand.
>
> (3) Risks apparent or known to the patient.
>
> (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
>
> (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(6) Information in cases where the patient is incapable of consenting.

¶13. The statute is basically divided into two parts: what information a treating physician is obligated to convey to a patient and what information he/she need not convey. The plain language of the statute places an obligation on a physician to provide information only about available and viable options of treatment.

¶14. In addressing the obligatory first part of the statute, our supreme court has declared: "[W]hat a physician must disclose is contingent upon what, under the circumstances of a given case, a reasonable person in the patient's position would need to know in order to make an intelligent and informed decision." *Johnson v. Kokemoor*, 199 Wis. 2d 615, 639, 545 N.W.2d 495 (1996). Restricting the application of the obligation, we declared in *Mathias v. St. Catherine's Hospital, Inc.*, 212 Wis. 2d 540, 569 N.W.2d 330 (Ct. App. 1997): "The law in Wisconsin on informed consent is well settled. . . . the duty to advise a patient of the risks of treatment lies with the doctor. . . . The court was explicit in pointing out that the duty to obtain informed consent lay with the doctor, not the

hospital." *Id.* at 548 (citations omitted).[3] Thus, St. Mary's Hospital was not a proper defendant. We continue the analysis then only as the second claim applies to Arnold and Berkoff.

¶15. Doubtless, the doctrine of informed consent comes into play only when there is a need to make a choice of available, viable alternatives. In other words, there must be a choice that can be made. The process of decision-making necessarily implies assessing and selecting an available alternative. In the context of treatment required after the cesarean procedure was performed on Emanuel, there are two reasons why no available, viable alternative existed to give rise to the obligation to engage in the informed consent process.

¶16. First, requiring the informed consent process here presumes that a right to decide not to resuscitate the newly born child or to withhold life-sustaining medical care actually existed. This premise is faulty. *In Edna M.F. v. Eisenberg*, 210 Wis. 2d 557, 568, 563 N.W.2d 485 (1997), our supreme court set forth the preconditions required for permitting the withholding or withdrawal of life-sustaining medical treatment.

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[3] The dismissal of St. Mary's Hospital at the complaint stage has not been addressed by the plaintiffs. We therefore deem the issue abandoned. *See Reiman Assocs. v. R/A Adver. Inc.*, 102 Wis. 2d 305, 306 n.1, 306 N.W.2d 292 (Ct. App. 1981).

There, the appointed guardian of her incompetent sister, Edna, sought permission to direct the withholding of medical care from Edna even though she was not in a persistent vegetative state. *Id.* at 559-60. She claimed that Edna would not want to live in her condition, completely dependent on others for her care and existence, non-responsive and immobile. *Id.* at 560-61. The court, in refusing to extend the right to refuse life-sustaining medical treatment beyond individuals in a persistent vegetative state, relied on the analysis of the United States Supreme Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990): "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Edna M.F.*, 210 Wis. 2d at 563 (quoting *Cruzan*, 497 U.S. at 282).

¶17. The *Edna* court, in examining the sensitive issues before it and the need to balance the interests of the individual versus those of the state, was quick to appreciate the consequences of ultimate decisions made by third-party surrogates for those who cannot speak for themselves. It thus concluded that either withholding or withdrawing life-sustaining medical treatment is not in the best interests of any

patient who is not in a persistent vegetative state. *Edna M.F.*, 210 Wis. 2d at 566-68. Thus, in Wisconsin, in the absence of a persistent vegetative state, the right of a parent to withhold life-sustaining treatment from a child does not exist. It is not disputed here that there was no evidence that Emanuel was in "a persistent vegetative state." Accordingly, the alternative of withholding life-sustaining treatment did not exist.

¶18. The second reason why a viable alternative did not exist to trigger informed consent is the existence of the United States Child Abuse Protection and Treatment Act (CAPTA) of 1984, Pub. L. No. 98-457, 98 Stat. 1749 (codified at 42 U.S.C. § 5101 et. seq.). Because Wisconsin has fulfilled the necessary obligations to receive federal funds under CAPTA, CAPTA and its regulations are fully applicable in this state. *Jeanine B. v. Thompson*, 967 F. Supp. 1104, 1111-12, 1118 (E.D. Wis. 1997).

¶19. CAPTA was enacted to establish eligibility for states to obtain federal funding for the prevention of child abuse and to develop and implement a successful and comprehensive child and family protection strategy. Under CAPTA, states must have in place procedures for responding to child neglect. 42 U.S.C. § 5106(b)(4)(C). The Act includes a provision preventing "the withholding of medically indicated treatment from a disabled infant with a life-threatening condition." 45

C.F.R. § 1340.15(b)(1). In the regulations enacted under the statute, "withholding of medically indicated treatment" is defined as "the failure to respond to the infant's life-threatening conditions by providing treatment . . . which, in the treating physician's . . . reasonable medical judgment, will be most likely to be effective in . . . correcting all such conditions. . . ." 45 C.F.R.§ 1340.15(b)(2). The regulations further include the "authority to initiate legal proceedings . . . to prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions." 45 C.F.R. § 1340.15(c)(2)(iii). The implied choice of withholding treatment, proposed by the plaintiffs, is exactly what CAPTA prohibits.

¶20. It is noteworthy that in the complaint, plaintiffs did not allege that Emanuel was born with a known disability or that they would have chosen to withhold life-sustaining treatment. Instead, they allege that they were not given the statistics about the possible risks that he could develop a disability if he lived, and they should have been given the opportunity to withhold life-saving measures immediately after Emanuel's birth. Under the common law of Wisconsin and federal statutory law, however, Emanuel's parents did not have the right to withhold or withdraw immediate post-natal care

from him. Thus, no viable alternative health treatment existed to trigger the informed consent process.[4]

¶21. We now examine the applicability of the second part of the informed consent statute; i.e., the six exception sections, providing conditions under which the treating physician is not obligated to inform the patient. Germane to our analysis is subsection (5) which renders unnecessary the disclosure of "information in emergencies where failure to provide treatment would be more harmful to the patient than treatment."

¶22. The complaint alleges that "attempts . . . to interrupt the preterm labor . . . [were] unsuccessful" resulting in

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[4] In *Iafelice v. Zarafu*, 534 A.2d 417 (N.J. Super. Ct. App. Div. 1987), the New Jersey Appellate Division examined the exact same issue presented by this appeal and exclaimed:

> The mistaken premise of this appeal is that allowing the child to die untreated was a legally viable alternative . . . we find no support for the belief that a newborn child may be put to death through [allowing a natural delivery with no resuscitation efforts upon birth] on the mere expectation that she will, in some unquantified way, be a defective person. As the Supreme Court wrote in ***Berman v. Allan***, 80 N.J. 421, 430, 404 A.2d 8 (1979), "It is life itself, that is jealously safeguarded, not life in a perfect state."

Id. at 418.

Emanuel's premature birth by cesarean section, and that "upon Emanuel Vila's delivery, he was immediately handed off to defendant Brent Arnold, M.D. who initiated heroic and extraordinary life saving measures" on him. The allegations suggest that an emergency arose requiring an immediate response, which occurred. Montalvo does not suggest that all emergency actions should have ceased while Arnold explained possible options. Such an argument would be frivolous. Given the allegations of the complaint, it cannot be gainsaid that failure to provide treatment would have been more harmful than treatment.

¶23. Although Montalvo concedes that as parents they have "no right to terminate the child's life," they assert that if "there is a balance between giving therapies that help, but which may also seriously harm, the parents should be the final arbiters of that choice." In the exigent circumstances confronting the treating physician here, no "balance" existed as proposed by the parents. Failure to treat was tantamount to a death sentence. Under the pleaded circumstances, informed consent was not required.

C. Public Policy.

¶24. The trial court, in rendering its oral decision reasoned:

> That as far as I can read from reading the materials in the complaint that presumes that the parents had a legally enforceable right to reject or withhold treatment. From what is alleged in the complaint there was no gap, space in time for which they could sit down and discuss statistics or any other manners of dealing with the situation. It was a life or death situation. When a child is not breathing there is no time --there is no time. Any --any amount of loss of oxygen could be devastating to the child certainly. . . .
>
> . . . What the doctors did was save this child's life, and I understand the legal position of the parents is that was a decision they should make, but I don't believe that's one that we as a community in our public policy that's been adopted by our state and our court can place wholly in the hands of the parents.
>
> Protection of children is something that the community has an interest, in and a parent does not have the right to withhold necessary emergency treatment, and I agree entirely that had the doctors acted in any other way they would face not only civil -- civil cases against them but possibly criminal cases. We simply can't say that the possibility that this child could be disabled or even the probability if it is that strong is sufficient to withhold li[f]e-saving

> measures and decide this child does not deserve to live.

Without a doubt, a major underpinning of the court's decision was public policy.

¶25. In Wisconsin, the interest in preserving life is of paramount significance. *L.W. v. L.E. Phillips Career Dev. Ctr.*, 167 Wis. 2d 53, 90, 482 N.W.2d 60 (1992). As a result, there is a presumption that continued life is in the best interests of a patient. *Id.* at 86. In the absence of proof of a persistent vegetative state, our courts have never decided it is in the best interests of a patient to withhold or withdraw life-sustaining medical care. When appropriate circumstances are present, Wisconsin courts have not hesitated to dismiss complaints on public policy grounds, particularly where allowing recovery would place an unreasonable burden on physicians or where allowing recovery would provoke an exercise that has no sensible or just terminal point. *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 518-19, 219 N.W.2d 242 (1974).

¶26. The physicians involved in the resuscitation measures could be faced with a "damned if you do, damned if you don't" dilemma as demonstrated by the result of *Burks v. St. Joseph's Hospital*, 227 Wis. 2d 811, 596 N.W.2d 391 (1999). In Burks, the physicians made a decision not to resuscitate based upon a judgment that a premature baby was not viable. *Id.* at 813.

The baby died. *Id.* The parents brought a claim under the Emergency Medical Treatment and Active Labor Act (EMTALA) against the physician who determined that the infant was not viable and who did not resuscitate the child. *Id.* at 814. The claim was allowed because a hospital is required to provide emergency room patients with a medical screening examination including care to stabilize them. *Id.* at 817-18. If treating physicians can be sued for failing to resuscitate a baby they feel is not viable, and for resuscitating a viable baby such as Emanuel, they are placed in a continuing "damned" status. The public policy of Wisconsin does not tolerate such a "lose-lose" enigma.

¶27. If the parents' claim is allowed to proceed, courts will be required to decide which potential imperfections or disabilities are, as characterized in appellant's brief, "worse than death." They will have to determine which disability entitles a child to live and which disability allows a third-party surrogate to withhold or withdraw life-sustaining treatment with the intent to allow a disabled person to die. This determination could vary greatly based on the parents' beliefs. One set of parents may view a particular disability as "worse than death," while another set of parents would not. Such a process, not unreasonably, has kaleidoscopic, unending

implications. The trial court did not err in reaching its conclusion based upon public policy reasons.

By the Court. --- Judgments affirmed.

Recommended for publication in the official reports.

STATE OF WISCONSIN	CIRCUIT COURT	MILWAUKEE COUNTY

NANCY MONTALVO and BRIAN VILA, EMANUEL L. VILA, a minor by his Guardian ad litem, Timothy J. Aiken,

Plaintiffs,

BLUE CROSS BLUE SHIELD UNITED OF WISCONSIN, STATE OF WISCONSIN MEDICAL ASSISTANCE PROGRAM-TITLE 19 and PRIMECARE HEALTH PLAN, INC.,

Case No. 99-CV-009500
Med. Mal-Ch. 655
Code No. 30104

Involuntary Plaintiffs,

vs.

WISCONSIN PATIENTS COMPENSATION FUND, TERRE BORKOVEC, M.D., ABC INSURANCE COMPANY, BRENT W. ARNOLD, M.D., DEF INSURANCE COMPANY, JONATHAN H. BERKOFF, M.D., GHI INSURANCE COMPANY, ST. MARY'S HOSPITAL OF MILWAUKEE, AND JKL INSURANCE COMPANY,

FILED
CIVIL DIVISION
MAY 2 2001
JOHN BARRETT
CLERK OF CIRCUIT COURTS

Defendants.

ORDER FOR JUDGMENT

The above-captioned matter having coming [sic] before the Circuit Court for Milwaukee County, the Honorable Mel Flanagan, Circuit Court Judge, presiding, on the defendants' motion to dismiss, and the plaintiffs having appeared by Kelly Centofanti of Aiken & Scoptur, S.C., the Wisconsin Patients Compensation Fund having appeared by Jeremy Gill of Nash, Spindler, Dean & Grimstad, S.C., the defendant Brent W. Arnold, having appeared by Pamela Morris of Hinshaw & Culbertson, S.C., the defendant Jonathan H. Berkoff, having appeared by Linda E.B. Hansen of Nilles & Nilles, S.C., and the defendant St. Mary's Hospital of Milwaukee, having appeared by Marilyn M. Carroll of Kravit, Gass, Hovel & Leitner, S.C., and the court having read the briefs, and listed to oral argument on the issues, and having granted the motion to dismiss for failure to state a claim upon which relief can be granted.

IT IS HEREBY ORDERED that all claims and causes of action set forth in the pleadings against Wisconsin Patients Compensation Fund, Brent W. Arnold, M.D., Jonathan H. Berkoff, M.D. and St. Mary's Hospital of Milwaukee, be and hereby are dismissed, on the merits, with costs in favor of the defendants and against the plaintiffs, Nancy Montalvo, Brian Vila and Emanuel L. Vila, by his Guardian ad litem Timothy J. Aiken.

Dated this 2 day of May, 2001.

BY THE COURT:

/s/
Hon. Mel Flanangan

FILED
CIVIL DIVISION
MAY 2 2001
JOHN BARRETT
CLERK OF CIRCUIT COURTS

Wisconsin Statute Section 448.30
Information on alternate modes of treatment.

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.

(2) Detailed technical information that in all probability a patient would not understand.

(3) Risks apparent or known to the patient.

(4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.

(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(6) Information in cases where the patient is incapable of consenting.

42 U.S.C. Sec. 5101
Office of Child Abuse and Neglect

(a) Establishment

The Secretary of Health and Human Services may establish an office to be known as the Office on Child Abuse and Neglect.

(b) Purpose

The purpose of the Office established under subsection (a) of this section shall be to execute and coordinate the functions and activities of this subchapter and subchapter III of this chapter. In the event that such functions and activities are performed by another entity or entities within the Department of Health and Human Services, the Secretary shall ensure that such functions and activities are executed with the necessary expertise and in a fully coordinated manner involving regular intradepartmental and interdepartmental consultation with all agencies involved in child abuse and neglect activities.

45 C.F.R. §1340.15 (a) - (b)
Services and Treatment for disabled infants

(a) Purpose. The regulations in this section implement certain provisions of the Act, including section 107(b)(10) governing the protection and care of disabled infants with life-threatening conditions.

(b) Definitions. (1) The term "medical neglect" means the failure to provide adequate medical care in the context of the definitions of "abuse and neglect"' in section 113 of the Act and Sec. 1340.2(d) of this part. The term "medical neglect" includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.

(2) The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's (or physicians') reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's (or physicians') reasonable medical judgment any of the following circumstances apply:

(i) The infant is chronically and irreversibly comatose:

(ii) The provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life- threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

(3) Following are definitions of terms used in paragraph (b)(2) of this section:

(i) The term "infant" means an infant less than one year of age. The reference to less than one year of age shall not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age, or to affect or limit any existing protections available under State laws regarding medical neglect of children over one year of age. In addition to their applicability to infants less than one year of age, the standards set forth in paragraph (b)(2) of this section should be consulted thoroughly in the evaluation of any issue of medical neglect involving an infant older than one year of age who has been continuously hospitalized since birth, who was born extremely prematurely, or who has a long-term disability.

(ii) The term "reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.